INTERIM STUDY COMMITTEE ON MEDICAID OVERSIGHT

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MEETING MINUTES[1]

Meeting Date:	**October 11, 2000**
Meeting Time:	**10:30 A.M.**
Meeting Place:	**State House, 200 W. Washington St., Room 233**
Meeting City:	**Indianapolis, Indiana**
Meeting Number:	**4**

Members Present: **Rep. William Crawford, Chair; Rep. Charlie Brown; Rep. Susan Crosby; Rep. Mary Kay Budak; Rep. Gary Dillon; Rep. Dave Frizzell; Sen. Patricia Miller, Vice-Chair; Sen. Rose Antich.**

Members Absent: **Sen. Marvin Riegsecker; Sen. Robert Meeks; Sen. Vi Simpson; Sen. Samuel Smith, Jr.**

Rep. William Crawford, Chair, called the fourth meeting of the Interim Study Committee on Medicaid Oversight to order at 10:35 a.m.

Consideration of HEA 1130 (2000)

Rep. Crawford explained that HEA 1130 (2000) (see Exhibit 1) was a product of the Select Joint Committee for Medicaid Oversight in 1999. The bill was authored by Rep. Vaneta Becker, passed the House by a vote of 94-0, and passed the Senate (46-1). The conference committee report passed both chambers unanimously, but the bill was vetoed by the Governor because of its fiscal impact. Rep. Crawford briefly described the bill.

Rep. Budak provided an update on the Stella Hahn case (heard in a previous meeting) and stated that she and Rep. Pelath had been working on her behalf. She stated that much of Ms. Hahn's problem, an inability to find nurses to provide home health services, is a result of low Medicaid reimbursement rates. She added that, even though HEA 1130 may not directly affect home health reimbursement rates, low rates can affect access to services. Rep. Budak

[1] Exhibits and other materials referenced in these minutes can be inspected and copied in the Legislative Information Center in Room 230 of the State House in Indianapolis, Indiana. Requests for copies may be mailed to the Legislative Information Center, Legislative Services Agency, 200 West Washington Street, Indianapolis, IN 46204-2789. A fee of $0.15 per page and mailing costs will be charged for copies. These minutes are also available on the Internet at the General Assembly homepage. The URL address of the General Assembly homepage is http://www.ai.org/legislative/. No fee is charged for viewing, downloading, or printing minutes from the Internet.

suggested that the Committee recommend overriding the Governor's veto to the General Assembly.

Responding to a question, staff briefly described the differences between HEA 1130 (2000) and PD 3300 (2001) (see Exhibit 2) regarding the provisions reestablishing the Committee for Medicaid Oversight. Staff stated that establishment of the Select Joint Committee in HEA 1130 was a non-code provision with an expiration date of December 31, 2001. On the other hand, PD 3300 establishes the Select Joint Commission as a statutory body with no expiration date. Both versions provide for operating under the policies of the Legislative Council except that both allow for meeting at any time during the calendar year. Also, the Commission under PD 3300 would not be required to file an annual report.

Dr. William Engle, representing the American Academy of Pediatrics, provided written testimony to the Committee (see Exhibit 3). Dr. Engle thanked the General Assembly for passing HEA 1130 and, although disappointed that the bill was vetoed, urged the Committee to recommend increasing Medicaid reimbursement rates now that the state budgetary concerns have been resolved. Dr. Engle stated that the state's outreach efforts have resulted in a 61% increase in children enrolled in the Hoosier Healthwise program over a 14-month period. He added that this has put increasingly heavy stress on Indiana physicians who want to serve all children but are unable to do so because they cannot personally afford to subsidize the larger number of Hoosier Healthwise patients.

Dr. Engle stated that the limited access to physician services was predicted and is due to the complexity of the reporting and reimbursement system; unpredictable, late, and low payments; and the less compliant Hoosier Healthwise patient population. He added that this is evidenced by the growing number of counties in which physician providers have filled their panels and the ten counties where no local physician providers are available.

Dr. Engle stated that Medicaid reimbursement rates have not increased for pediatric services in Indiana since 1994 despite continued increases in expenses for providing services. He added that, in 1999, Medicaid reimbursed physicians at rates lower than corresponding regional and national averages and at levels 20% to 70% lower than Medicare rates for children's services. Since physician services for children account for only 1.6% of the Medicaid budget, he stated that raising reimbursement rates to 100% of the Medicare rates will have a potentially large impact on access and a relatively small impact on the overall costs of the program. He added that research has shown that increasing Medicaid physician reimbursements by 10% increases participation by private practice physicians by 3%.

Dr. Engle stated that two problems exist as HEA 1130 is written: (1) there is no annual adjustment provided in the bill; and (2) costs of some drugs are very expensive and may take three to four years to work into the reimbursement system.

Rep. Crawford explained that the negotiation required to get HEA 1130 passed in a non-budget year was extensive. He encouraged people to participate and attend the budget hearings.

Ms. Laura Hahn, Indiana Academy of Family Physicians, thanked the Committee for their efforts with HEA 1130. She added that HEA 1130 was a good start, but physicians are still in need of relief. Ms. Hahn stated that if the Governor's veto is not overridden, she hoped that a new bill would be introduced.

Ms. Melissa Durr, Indiana Association of Area Agencies on Aging, being primarily concerned with the Medicaid reimbursement levels for waiver and home health services, stated that the provisions of HEA 1130 would not impact those rates. However, from her prior testimony before the Committee, she was asked to provide additional information. Ms. Durr provided waiting list

figures from Area Agencies on Aging by county (see Exhibit 4). Ms. Durr also provided materials to members in advance of the meeting relating to data requested at the August 25 meeting. The material relates to data about the lack of services or service providers for consumers on the Medicaid waivers (see Exhibit 5).

Ms. Durr stated that there was a 4.1% increase in reimbursement rates for waiver services, but that was the first rate increase there had ever been. Consequently, rates were at least 14% behind where they should be. She added that 82 providers cited low reimbursement rates as the reason for no longer providing services. She stated that the waiting lists add up to thousands of children. Ms. Durr stated that home and community-based waiver services are cost effective. She urged the Committee to recommend the following: (1) waiver reimbursement rates be increased to at least cover the cost of doing business; and (2) rates should be adjusted annually.

Rep. Crawford stated that the problem rests not only with the Office of Medicaid Policy and Planning (OMPP) since the General Assembly and the Governor establish the level of appropriations. He requested that Ms. Kathy Gifford, Assistant Secretary for OMPP, project the costs of serving everyone on the waiting lists.

Rep. Brown inquired as to why waiting lists for Lake County and Marion County were so large. Ms. Durr responded that the probable reasons include some reporting confusion, counties manage their waiting lists differently, but, mostly, because of population differences since those two counties are the largest in the state.

Rep. Budak asked if there was any discussion as to why we don't provide incentives for people to go into the care-giving profession. Ms. Durr responded that they are looking into possibilities, but increasing reimbursement rates would help.

Ms. Carol Caldwell, Indiana Psychological Association, stated that psychologists do want to provide services, as long as it is financially feasible. Ms. Caldwell related the costs of psychological assessments and stated that the assessments provide a realistic basis for forming diagnoses. However, the Medicaid reimbursement levels barely cover the costs of the assessments before the psychologist invests any time. She added that Medicaid reimbursement is based on Medicare reimbursement rates, but the Medicare reimbursement is flawed. Consequently, psychologists are becoming more reluctant to treat Medicaid patients.

Ms. Gifford reminded the Committee that HEA 1130 only relates to reimbursement rates determined through the methodology known as a Resource-based Relative Value Scale (RBRVS) system. Consequently, the bill only affects rates for physicians, chiropractors, psychologists, etc. The methodology does not affect reimbursement for home health services and waiver services. These are determined using a different methodology. She noted that the economy is having an effect on the ability to find nurses and service providers in addition to the effect of reimbursement levels.

Ms. Gifford added that most reimbursement systems are rule-based and, thus, rates can be changed administratively.

Rep. Brown inquired as to the fiscal impact of moving Indiana's rates to the regional average. Ms. Gifford responded that estimating the impact is difficult. She added that LSA prepared a fiscal note to an earlier version of HEA 1130 that proposed that methodology. Rep. Brown requested that staff provide the fiscal note to the Committee.

Staff also provided details regarding the effective dates resulting from a veto override. Staff stated that current statute provides that provisions with "Effective Upon Passage" or

"Retroactive" become effective once the vote for override is approved by both chambers. However, provisions with a "July 1, 2000" date would become effective "July 1, 2001."

Medicaid Managed Care Access To Drugs

Rep. Crawford opened the discussion of access to drugs in Medicaid managed care organizations (MCOs) by asking Ms. Gifford why MCOs have drug formularies. Ms. Gifford responded that she prefers to call them "preferred drug lists" because all drugs that are available under the Medicaid fee-for-service program are also available under the Medicaid Risk-Based Managed Care (RBMC) program. MCOs have developed their drug lists based on quality and cost considerations. Rep. Crawford stated that this imposes impediments to access for certain drugs.

Sen. Antich inquired as to why the prior approval (PA) lists of the three MCOs are so different: CIMCO (Central Indiana Managed Care Organization) has 23 drugs on their PA list, Maxicare has seven drugs, but Managed Health Services (MHS) require PA for 167 drugs. Ms. Gifford stated that each MCO is responsible for managing the care of their members, regardless of the type of care required. All the MCOs must provide access to all drugs. However, each can try and manage the patient's care. Sen. Antich stated that Medicaid recipients in Lake County, because they are subject to MHS's PA list, do not have the same access to drugs that other counties may have.

Ms. Gifford, responding to a question, stated that MHS is a sub-contractor in the northern and southern regions and the prime contractor in the central region of Indiana. MHS does not have exclusive jurisdiction in Lake County since the Medicaid Primary Care Case Management Program (PCCM) also operates there. Also, MHS contracts with a network of pharmacies, including CVS, Osco, and independent pharmacies. MHS has a pharmacy benefit manager, MIM, to which all pharmacies under contract with MHS submit their claims. MHS contracts with several pharmacies in order to have sufficient geographic coverage (e.g., there are no CVS stores in Gary).

Regarding the process used by the Drug Utilization Review (DUR) Board in overseeing the development of drug formularies by the MCOs, Ms. Gifford asserted that the DUR Board was in full compliance with state statute. Ms. Gifford provided a complete record to the Committee of the DUR proceedings (see Exhibit 6).

Mr. Charles Hiltunen, representing Phizer, stated that his concern is that the DUR Board made decisions regarding Zithromax that were not based on complete information. He stated that the evidence that was provided in support of requiring PA for Zithromax involved ear infections and antibiotic resistance. However, the PA process has serious implications for access and that requiring PA for ear infections effectively restricts access to Zithromax for other medical problems.

Dr. George Rubeiz, a practicing physician of pulmonary and internal medicine in Indianapolis, testified that medical decisions should be left to the individual physician and if a drug is being used inappropriately, then education is needed rather than restricting use of the drug. The consequences of restricting a drug by PA are that the drug won't be used very much: the "prescribing pattern" of a physician is changed. Dr. Rubeiz added that most physicians would not prescribe a drug that won't work.

Dr. Michael Kays, Assistant Professor of Pharmacy Practice at Purdue University, addressed the problem of antibiotic resistance and provided a document entitled "Antimicrobial Resistance in *Streptococcus pneumoniae*" (see Exhibit 7). He stated that he is a member of the Indiana Coalition for Antimicrobial Education Strategies (ICARE), an organization that promotes the

judicious use of antibiotics. Dr. Kays discussed aspects of resistance and the need to find ways to limit the overuse of antibiotics.

Rep. Dillon stated that doctors are faced with a dilemma in that they don't really know if bronchitis, as an example, is viral or bacterial. Consequently, they may feel a need to treat with an antibiotic in case it is bacterial. Dr. Richard Feldman, Commissioner of the State Department of Health but speaking as a family physician, stated that usually enough clues can be obtained in the examination so that the physician can be right 90% of the time. He added that there is a lot of pressure on physicians to throw antibiotics at patients.

Ms. Karen Lloyd, an attorney from Ice Miller representing MHS, briefly reviewed the process used by MCOs to place a drug on a formulary. She stated that the process is about the same as in any other managed care organization. She added that, in the event that there is no opportunity to receive prior approval, the doctor can use anything for a 72-hour period. She stated that there were, by her count, 172 drugs on MHS's formulary with 71 of them requiring PA. She added that MIM, MHS's pharmacy benefit manager, receives more than 300 calls per month seeking PA and that 80% are approved.

Rep. Crawford stated that three amendments to the DUR statute (see Exhibit 8) will be considered at the final meeting. The amendments involve the following: (1) Prohibiting prior authorization with Medicaid managed care plans except in situations where the drug is subject to clinical abuse; (2) Providing that the DUR Board is to determine if restrictions to a drug on the Medicaid drug formulary impedes the quality of patient care or increases other health care costs; and (3) Tightening up the DUR Board's review of restrictions to Medicaid managed care formularies. Rep. Crawford requested that staff draft the three amendments into bill form for consideration at the next meeting.

Rep. Brown asked whether there is a way to minimize the frustration and inconvenience to physicians associated with having to comply with several formularies. Dr. Feldman responded that the only real solution would be a common formulary.

Ms. Gifford stated that there is no consistency or uniformity in formularies in the commercial world, either. She added that many of the Hoosier Healthwise patients are children and that there may be a developing public health crisis with respect to antibiotic resistance, especially with children. The DUR Board was merely responding to this problem. She stated that it is not desirable to have unnecessary and burdensome PA procedures. PA is best used where utilization needs to be controlled. Certain tools available in the private sector (such as three-tiered pricing) are not available to the Medicaid program, especially with respect to children. She reiterated that this is a quality of care issue.

Risk-Based Managed Care Issue

Ms. Deborah Daniels, representing Gary Methodist Hospital, Gary, IN, briefly summarized this issue for the Committee and introduced Mr. John Diehl, CFO of Gary Methodist Hospital.

Mr. Diehl provided written testimony and background information to the Committee (see Exhibit 9). Mr. Diehl stated that Gary Methodist Hospital has had numerous and serious problems in their contractual relationship with Managed Health Services (sub-contractor to Maxicare in the northern Indiana region in the Medicaid Risk-Based Managed Care Program). Mr. Diehl reported that Gary Methodist was only trying to get a level playing field and that the situation has worsened since the issue was examined during the 2000 legislative session. In addition, this problem may have broader policy implications. Problems described by Mr. Diehl and provided in detail in Exhibit 9 include, but are not limited to, the following: (1) MHS failing to respond to letters regarding disputed claims denials; (2) approximately 97% of all claims

payments being disputed by Gary Methodist; (3) the handling of claims inquiries by MHS is extremely burdensome on Gary Methodist; (4) all emergency room claims are paid at flat $35 fee regardless of the diagnosis or the services the patient receives; and (5) frequent denial that a patient is enrolled in the RBMC program resulting in denial of payment. Financial data is also provided in the exhibit.

Mr. Tim Kennedy, Indiana Hospital and Health Association, stated that there were things that could be learned from this situation, including the following: (1) It is appropriate for the General Assembly to look at tools that OMPP can use to discipline contractors that are not compliant with the rules and laws; (2) It is appropriate for the General Assembly to look at tools that OMPP can use to make certain bidders ineligible for a contract based on past behavior; (3) Federal law does not differentiate between types of emergency (as is being claimed that MHS is doing);and (4) There is a flaw in SEA 455 (2000) which needs to be fixed regarding the arbitration of disputed claims (SEA 455 was a bill specifically addressing the situation between Gary Methodist and the MCO). Mr. Kennedy added that the provisions of SEA 455 expire December 31, 2000, and he has serious concerns about how this situation will be handled by the parties after that time. He also stated that one of the complicating factors in this situation is that MHS and Gary Methodist are currently operating without a contract.

Ms. Karen Lloyd, Ice Miller representing MHS, stated that there had been problems between MHS and Gary Methodist, but they felt that they had been working toward a resolution. MHS had prepared a "green bar" summary of a portion of the disputed claims and they were preparing to meet with Gary Methodist during the week following this Committee meeting. She stated that MHS complies with the "clean claims" statute, as does the Medicaid program. She also confirmed that MHS has an internal appeals process and MHS is willing to work with a third-party or arbitrator to resolve the differences with Gary Methodist. Ms. Lloyd also stated that it is their belief that MHS is not in violation of the provisions of SEA 455.

Ms. Gifford stated that MCOs have hundreds of contracts with providers and that this represents a dispute between two commercial entities. She added that OMPP is not well situated to monitor and resolve commercial disputes.

Mr. Mike McKinney, Medical Director of MHS, stated that this has caught him off-guard: he thought MHS and Gary Methodist were moving forward on these problems. He reiterated that a managed care organization can only base their emergency room reimbursement decisions on "clinical presentation" and not on "diagnosis." Responding to a question from the Committee on MHS's policy for dispute resolution, Mr. McKinney stated that MHS has an appeal process. He also confirmed that MHS's time line for reimbursement mirrors the "clean claims" provisions for Medicaid reimbursement currently in statute. Mr. McKinney also acknowledged that Gary Methodist is unique because it is a hospital serving a disproportionate share of the indigent community, and consequently is an integral part of that community.

Rep. Crawford stated that he hopes that MHS and Gary Methodist are moving to some resolution of this problem because the citizens of Gary deserve the right to access health services. Rep. Crawford added that he would like for the two parties to report on their progress at the Committee's next meeting.

Rep. Brown provided to the Committee a copy of an article entitled "Pill Prices Hard to Swallow" from the Gary Sunday Post-Tribune, October 8, 2000 (see Exhibit 10). The article reports on the variation in pharmaceutical prices from store to store and even between stores within the same pharmaceutical chain.

Mr. Grant Monahan, Indiana Retail Council, responded to Rep. Brown stating that he has faxed the Post-Tribune article to his members for their comments. He added that operational costs

can differ between stores and can contribute to price differences, as can competition in the marketplace. Mr. Monahan suggested that it is always good practice to shop around, although there are many factors besides price that influence an individual's pharmaceutical purchases.

Rep. Crawford stated that the next meeting would be on Wednesday, October 25 at 10:30 a.m. in Room 233 of the State House. The next meeting will be the final meeting of the Committee and any legislative recommendations by the Committee will need to be voted on at that time.

There being no further business to conduct, the meeting was adjourned at 2:30 p.m.